California Department of Aging (CDA) Community-Based Adult Services (CBAS) Home and Community-Based (HCB) Settings Individual Plan of Care (IPC) Revision Workgroup Meeting Summary October 7, 2015	
Meeting/ Webinar Date	October 7, 2015 1 p.m. to 3:30 p.m. California Department of Aging (CDA)
Workgroup Member Attendees	In-Person: 7 Webinar Registrations: 21

Meeting Agenda	• Welcome, Introductions & Overview of Meeting Agenda and Objectives
	• Review Workgroup Charter & Deliverables
	• Review STC 96(c) and Federal Regulations for Person Centered Planning (42 CFR 441.301(c)(1)-(3))
	• Walkthrough of CBAS IPC & Identify Potential Revisions to Comply with STC 96 and Federal Regulations
	  ○ Remarks By: Amanda Sillars (ADHC Solutions) and Lydia Missaelides (CAADS)
	• Identify Overlapping Issues with Quality Workgroup
	• Review Action Items/Identify Next Steps/Schedule Next Meeting
	  ○ Suggestions for Ad Hoc group work between meetings?
	• Meeting Adjourned

Meeting Highlights	**<u>Welcome, Introductions & Overview of Meeting Agenda and Objectives</u>** The following are highlights of workgroup member recommendations for IPC revisions: • Last IPC revision was at time of transition to CBAS in 2012—revisit some of the issues tabled at that time • Revise IPC structure/format and include information about person-centered care/planning • Reflect what services are provided at the center—do not include too much regulatory information • Provide more information about the Interdisciplinary/Multidisciplinary Team • Promote efficiencies and effectiveness of documentation to allow more time to focus on providing services to CBAS participants • Promote outcome-oriented documentation • Reflect the coordination and collaboration between CBAS providers and managed care plans • Provide vehicle to improve transmission of information between CBAS

providers and managed care plans—move toward electronic submission

Review Workgroup Charter & Deliverables

- Refer to the IPC Revision Workgroup Charter posted on CDA website
  - Workgroup recommended revising the language about "elimination of ADHC as a Medi-Cal benefit" and adding language about the need for training in the roll-out of the revised IPC
  - Review/approve revised charter at December meeting
- Background on establishment of the IPC Revision Workgroup:
  - Recommendations to revise the IPC arose during the CBAS 1115 Waiver stakeholder process which dovetails with the federal Home and Community-Based Services Rule and person-centered planning requirements as specified in the CBAS provisions of the 1115 Waiver

Review STC 96(c) and Federal Regulations for Person Centered Planning (42 CFR 441.301(c)(1-3))

- The Affordable Care Act as reflected in 42 CFR 441.301(c)(1-3) delineates the federal expectations/directives for the person-centered planning process, the content of the individual plan of care and the review/re-assessment process for all home and community-based settings not just CBAS
- CBAS provisions of 1115 Waiver in STC 96(c) identifies the person-centered planning requirements for CBAS to be documented in the CBAS Individual Plan of Care (IPC)
- Workgroup will cross-walk the federal requirements with the existing CBAS IPC to determine IPC revisions
- Other providers are developing care plans in addition to CBAS which results in multiple care plans at different levels for the same person, each with a different focus/purpose—need to figure out the relationship among various care plans to prevent working at cross-purposes
- Review All Plan Letter 14-10 on care coordination requirements for managed care plans
  - CBAS IPC can promote coordination of care between CBAS center and managed care plans for CBAS participants
- Need to determine managed care plan role with regard to CBAS IPC—managed care plans identify overarching goals for participant's care while CBAS centers provide the services
- Issues to address in the IPC will arise during the inventory of existing IPC related to the federal requirements—will look at each federal directive to determine if it is reflected or not in the CBAS IPC
- Need to meet the federal standards for all CBAS participants even if not all participants need the same level of services/service planning—need to deliver the right services at right time at right level of frequency to

	meet participant needs
	
	<u>Walkthrough of CBAS IPC & Identify Potential Revisions to Comply with STC 96 and Federal Regulations</u>
	
	<u>Overview of Approach to Revising the IPC</u>
	• Review the content and structure of the IPC
	• Develop a work tool to determine if the current CBAS IPC addresses the federal requirements to identify the revisions needed
	• Standardize supporting documents to the IPC to satisfy the federal requirements such as the Participation Agreement
	• Along with revising the IPC document, evaluate the processes to complete the IPC that support person-centered planning
	
	<u>Remarks By Amanda Sillars, MSW, LCSW (Founder, ADHC Solutions Inc.)</u>
	Amanda Sillars presented a comparison of the Medical Model (MM) and Person-Centered Care Model (PCCM)—refer to presentation handout posted on CBAS Workgroup Meeting webpage:
	• MM treats the diagnosed condition; PCCM treats the entire person
	• MM focuses on the individual; PCCM is a team model
	• CBAS regulations are team based
	• PCCM involves the participant in his/her own care—the participant and staff are considered equal with respect to one another's expertise
	• PCCM has been proven to improve outcomes
	• PCCM uses functional language:
	  ○ Example: Mrs S wants to be able to take a walk in her garden without falling (rather than Mrs. S is a fall risk related to arthritis)
	• Create an IPC that is need-based vs diagnosis-driven
	• Interaction of diagnoses/conditions is critical—Example: how are diabetes and blood pressure affecting each other
	• Person-centered care:
	  ○ Treat the person not the disease
	  ○ CBAS participant describes what is most problematic for him/her to promote quality of life
	  ○ CBAS participant has an active role in his/her plan of care
	  ○ Identify how the team can support the participant to achieve goals
	  ○ CBAS goal is to empower participants to take care of themselves
	  ○ Help participants identify what they want to change
	
	<u>Remarks by Lydia MIssaelides (Executive Director, California Association for Adult Day Services/CAADS)</u>
	• IPC can be used to document/measure outcomes—overlaps with CBAS Quality Workgroup
	• IPC ensures comprehensive view of whole person—identify how

	independent the person is as well as if requires care management services (not everyone requires care management services)
	• Identify right level of attention and services
	• IPC is a communication tool between CBAS centers and managed care plans about participants
	• Identify risk factors and behavioral anchors for activities of daily living and instrumental activities of daily living
	• Include information to paint picture of participant for health plans that has value/is useful
	
	<u>Workgroup Comments</u>:
	• Over the years there have been many different instructions for writing the CBAS IPC including directives from the Medi-Cal office
	• Identify who needs what information and why
	  ○ Different informational needs for managed care plans, CBAS center, participant, state oversight/monitoring
	• If the IPC only emphasizes strengths, then it will be difficult to understand why the participant needs CBAS
	• Need to write strength-based care plans
	• Need to balance documentation of participant's strengths and needs/problems
	• Aim for identifying all dimensions of participant care
	• Summary Page was eliminated but can be useful
	  ○ May complete Summary Page on some patients but not all—use it to fill in gaps when need to provide more information such as history of multiple hospitalizations
	• Medical necessity/eligibility is determined by managed care plans
	  ○ Managed care plans need sufficient information to determine medical necessity/eligibility if not complete a face-to-face assessment and to determine how many days of service to authorize to meet needs
	• IPC built on assessment process
	  ○ Need to look at whole person (bio-psycho-social-spiritual dimensions) as part of assessment
	  ○ Identify care management needs
	• Use person-centered language in documentation
	• Identify outcome measurements and how relates to frequency of services provided
	• Eliminate duplication of information
	• Design IPC around problem/needs and interventions, not by discipline
	  ○ The nurse, social worker, other treatment team members (including the participant) will provide interventions to meet the measurable goals for the identified problems/needs of the participant.

	○ Each discipline may provide interventions around the same identified problem/need based on their scope of practice • Identify the minimal amount of revisions to meet federal requirements • Create an IPC that does not get CBAS centers "in trouble"—managed care plans trust CBAS centers to monitor CBAS eligibility • Don't want to lose the clinical/medical information • Not all information on the IPC needs to be submitted to managed care plans • Information on the IPC needs to be auditable • Ensure various stakeholders review/provide feedback on IPC revisions • IPC needs to captures planned care and unplanned/emergent care • Clarify hierarchy of person-centered plans (CBAS IPC person-centered plan, overarching care plan by managed care plans, other?) <u>Walk-Through of Each Box in IPC</u> • Box 1: Treatment Authorization ○ Health plans can authorize IPC for 12 month period ○ State requires 6 month assessments/reassessments whether or not the health plans authorize the IPC for 12 months • Box 2: Diagnoses/ICD Codes (Primary/Secondary) ○ May want to change terminology ○ Need both primary and secondary? ○ Diagnoses confirmed by primary care physician (PCP) ○ Psychologists can diagnose ○ Consider social determinant health codes (ICD-10) ○ Consider functionality • Box 3: Medication ○ Title 22 Regulations ○ Include dosages? • Box 4: Physician/Address ○ Specify specialty (Primary Care, Psychiatrist, Other?) • Boxes 5-9: Eligibility Criteria ○ Problems with understanding/completing this section ○ Use eligibility screening tool from the ADHC-CBAS Transition (best practice screening tool) ○ Managed care plans determine eligibility through face-to-face ○ How do ADLs affect eligibility? ○ Use Summary Box if needed ○ Assessment process every 6 months • Box 10: For participants with diagnosed chronic mental illness ○ Used in 2007 IPC revision due to cross-over of participants getting county behavioral health services (CBAS and County Mental/Behavioral Health are not mutually exclusive benefits)

	○ Included in IPC to show CBAS center efforts to inform participants of availability of county behavioral health services ○ Managed care plans now have specific behavioral health responsibilities for their members in addition to county behavioral health services ○ Need to ensure that persons needing behavioral health services are identified and referred to the appropriate service provider ○ Determine in assessment process if participants are receiving county behavioral health services ○ Incorporate care coordination requirements ○ Requires more discussion • Box 11: ADL/IADL Limitations ○ Improvements? ○ Use behavioral anchors ○ Look at definitions at different points in time ○ Descriptions include “best day, worst day, at this moment” ○ Clarify need for supervision/verbal cuing ○ Include in all assessments and ensure consistency/uniformity in ADL/IADL assessment results—Multidisciplinary Team (MDT) to discuss if there are discrepancies in assessments • Box 12: Adaptive Devices • Box 13: Continence • Box 14: Feeding ○ Use Body Mass Index (BMI) for monitoring weight-not “underweight/overweight” • Box 15: Non-CBAS Services ○ Pull data from IPC • Box 16: Non-CBAS Support Services ○ Include dates, remove “explain” • Box 17: Risk Factors ○ Include additional risk factors such as social determinants, health literacy, health risk assessment elements identified by managed care plans and others ○ Define terms used, i.e., poor judgment? • Box 18: At risk for admission to acute or institutional care. ○ Capture elsewhere –Box 15? • Box 19: CBAS Core daily services ○ Perfunctory • Box 20: TAR for reauthorization of CBAS services ○ Include in Box 1? ○ Increase background info ○ Document progress made with federal requirements. • Boxes 21-22: Participant’s Individual Plan of Care (Core Services & Additional Services)

	○ Include transportation to and from center–plans would like to know this information ○ Consider Interdisciplinary Team (IDT) model—interventions provided by each discipline for identified problems/needs that cut across multiple disciplines ○ Identify measurable outcomes ○ Determine need for detail or narrative ○ What information do managed care plans need? ○ Trying to meet information needs by multiple audiences through IPC ○ Are there specific data elements in IPC that are predictive of number of days needed, i.e., function, behavioral health, physical therapy/occupational therapy, speech? ○ Can't fit all services needed into three days—too difficult/stressful for some participants • Box 23: Summary Box ○ Use to explain some issues in more detail if needed ○ Information in this box may be useful to managed care plans in determining case management service needs and authorization of service days ○ More discussion needed on how to make the information in the Summary Box more useful to managed care plans and CBAS providers **<u>Identify Overlapping Issues with Quality Workgroup</u>** • Determine measurable outcomes for IPC that reflect quality of care • More overlapping issues to be identified/discussed during the lunch meeting **<u>Review Action Items/Identify Next Steps/Schedule Next Meeting</u>** • CDA to revise CBAS IPC Revision Workgroup Charter for review at December meeting • Consider establishing sub-groups for work in-between meetings • CDA to develop IPC Revision Work Tool that identifies federal requirements for IPC • Presentation at December meeting by managed care plans on Health Risk Assessment elements to inform IPC revisions • Identify behavioral anchors for ADLs/IADLs • Present case example of Interdisciplinary Care Plan • Next meeting to be scheduled during first two weeks in December (10a.m.to 4p.m.)—both workgroups will meet on same day with working lunch to address overlapping issues

	○ Distribute survey monkey to workgroup members to determine best date for December meeting • Post meeting materials on CDA website